STANDARD OPERATING PROCEDURE
Restraints
SOP 16.6.1

Rev. 5/01

PURPOSE: THE PURPOSE IS TO PROVIDE GUIDELINES TO ENSURE THAT RESTRAINT USE IS RESTRICTED TO SITUATIONS THAT ARE MEDICALLY NECESSARY, AND THAT THEIR USE IS SAFE. ONLY SOFT RESTRAINT IS TO BE USED FOR MEDICAL RESTRAINT.

I. Therapeutic restraints carry a degree of risk. They may be used only when the following criteria are met:

A. Restraint use is necessary to prevent patient harm to self or others
B. Less restrictive interventions are considered and felt to be inappropriate or
C. inadequate.
D. Staff is trained and demonstrates competence in the safe and effective application
E. of restraints.
F. The risks to the patient of less restrictive interventions are felt to be greater than
G. the risks from restraint use.

II. The use of restraints should be minimized to the extent that is consistent with safe and effective psychiatric care and the specific needs of individual patients. The procedure for medical restraint use requires the following:

A. A physician must order the restraints.
B. A sufficient number of staff will apply the restraints to ensure detainee and staff safety.
C. An assessment and exam is performed to ensure that the detainee is safe once restraints are placed.
D. Monitoring and care of the detainee is documented on the Restraint Flow Sheet.
E. The restrained detainee will be observed every 15 minutes to ensure their continued safety and humane treatment.
F. Restraints will be removed when, in the physician's judgement, the detainee no longer poses a risk to self or others.
G. A mental health professional will evaluate the mental health needs and interventions required for the patient.

III. A staff debriefing, including the HSA and CD will follow each episode of therapeutic restraints. The evaluation will include an assessment of the factors leading to the use of restraints, steps to reduce future restraint use on the detainee, injury as a result of restraint

use, and the clinical impact on the detainee. The PI committee will evaluate all incidents with the goal of minimizing restraint use.

IV. In cases where the INS uses 4-point restraints for behavioral reasons, the medical staff is used as a consultant on restraint safety and is not involved in any way in disciplinary decisions or duration of restraint use and the clinical impact on the detainee. These requirements based on INS detention standards (security and control-use of force p.8) are as follows:

The medical staff will assess the detainee, after restraints are applied by the INS to ensure the safety of the detainee. The assessment will include vital signs, identification and documentation of any injuries, ensure that there is no alteration in circulation or airway obstruction, and that the positioning of the detainee is safe.

PROCEDURE:

STAFF	ACTION	RATIONAL
Clinical Staff	Code announced to assemble staff team and other clinical staff as appropriate	To assure the safety of the patients and others
Negotiator (Clinical staff in the immediate area who has the best rapport with the patient)	Attempts to de-escalate the patient through verbal intervention	To assess if physical intervention is necessary
Clinical Staff	Remove items from the area that could pose a danger to the patient or others	To protect patient and others
Clinical staff	Directs other detainees away from the scene	To protect patient and others
Team leader	If possible, obtain from the patient a verbal contract that he/she is able to bring their behavior under control	Attempt to calm patient and offer alternative behavior to loss of control
Team leader	Determine if the patient has regained control. If the patient has gained control allow patient to return to usual activities	Use the least restrictive method of control
Team leader	If the patient is unable to gain control, implement crisis control techniques to safely initiate the use of mechanical restraints	To prevent patient from injuring self or others
RN	Call physician to clinically assess the patient and obtain a verbal/telephone or written order. If unable to immediately	To assure appropriateness of restraints. To abide by state law. To ensure there are no contradictions for restraints

	contact a physician, the nurse may initiate restraint, but must obtain order with in one hour. No PRN orders are allowed.	
Team leader	Gives direction to assemble the restraint and utilize physical intervention as appropriate. Gives direction to apply the restraints assuring adequate circulation in all extremities	To provide safety for patient and others
RN	Assure that restraints are applied in a manner that allows the body to experience no unusual musculoskeletal position. Patients are always positioned on their backs in restraints.	To provide safety and comfort to the patient
RN	Make sure that restraints are appropriately fastened to avoid unnecessary pressure that would interfere with normal physiological processes. Check circulation on each limb	To prevent discomfort and/or difficulty in ventilation or circulation
HSA or RN	Will notify OIC INS when the patient is placed in restraints, and a second notification when released	To make INS aware of action
Team leader	Explain to the patient that the purpose of restraints is to protect them and others from injury until their behavior is under control	To decrease anxiety and fear
Clinical staff		

Clinical staff of the same sex	Do not apply restraints to only one side of the body nor just feet. If a patient has shown improved control, restraints may be decreased from all four limbs to two (i.e., Left arm and right leg)
RN	The patient should be searched and all potential harmful objects removed from him/her while in restraints (belts, sharp objects, etc.)
RN	Initiate Medical Observation of Detainee in Restraints Flowsheet. Monitor patient at all times on 1:1
RN	Assign 1:1 staff. Monitor that assigned staff document on the Observation of Detainee in Restraints Flow sheet the patient's needs (water, bathroom, circulation) are monitored at least every 15 minutes with regard to adequate nourishment and personal care.
	Document in progress notes a minimum of every hour and assesses: 1. Patient's physical condition 2. Patient's behavior 3. Patient's need to remain in restraints 4. Any other significant information

To prevent patient injury	To provide for continuous patient safety, and assure patient needs are continually met.	To assure patient needs are met and documentation indicates the care received
To assure patient safety	To assure patient needs are continually met and documentation indicated the care receive	
Assigned 1:1 staff	Document any significant observation, and RN notification as appropriate in progress notes	Clinical staff to indicate care provided to patient
RN	When the patient has regained control, gives direction and assists staff in releasing patient from restraints	Treatment in the least restrictive manner
RN	Fills out Post Restraints Observation Report and assures copies are routed appropriately.	To abide by National Policy